ACRL Allen County Right to Life

July 1, 2019

Angela Becker Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204

Dear Ms. Becker,

Pursuant to the provisions of governing law, including but not limited to, I.C. §§ 5-14-3-1 and 3, I am requesting copies of the abortion facility license applications and supporting documentation for new abortion facilities from June 7, 2019 through July 1, 2019. I am also requesting copies of the abortion facility license renewal applications and supporting documentation for all abortion facilities operating the state. Licenses for existing abortion facilities expire June 30, 2019 according to my records.

Please send to the address below or e-mail to cathie.humbarger@ichooselife.org.

Please let me know of any cost related to this request and I will remit payment immediately.

Mail to:

Cathle Humbarger, VP Indiana Right to Life 2126 Inwood Drive Fort Wayne, IN 46815

Sincerely,

Executive Director

Allen County Right to Life

Carlie Tumbarger



Eric J. Holcomb Kristina Box, MD, FACOG State Health Connulssioner

June 3, 2019

Facility 011133

LADONNA PRINCE, MANAGER CLINIC FOR WOMEN 3607 W 16TH ST STE 2B INDIANAPOLIS, IN 46222

Dear LADONNA PRINCE, MANAGER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN

Jennifs He Suc RN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

317/232-3095

Enclosure (1)



Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Counseling of Indiana Inc. d/b/a CLINIC FOR WOMEN

3607 W 16TH ST STE 2B INDIANAPOLIS, IN

an Abortion Canic, has fulfilled the requirements for Acensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011133-1 is effective July 1, 2019 and expires June 30, 2020.

O SUPPLIES OF STREET, STREET,

Kandall Sugder

RANDALL SNYDER PT, MBA DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH

MAY 3 1 2019

MAIL MONEY RECEIPT

Indiana Státe Department of Health

Acute Care Division

DATE

30-MAY-19

RECEIPT NO.

1964507

DIVISION

ACUTE CARE (AC)

FROM

CLINIC FOR WOMEN

STREET

3607 W 16TH ST

CITY

INDPLS

STATE IN

46222

BIRTHING CENTERS (Fund: 17610, Program: 30000, Account: 423060,

1,000,00

Department: 195129)

AMOUNT

\$

1,000.00

CASH

CHECKS AND

9011323982:

\$1,000.00

MONEY ORDERS

REFUND

MAIL CLERK Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

30-MAY-19

RECEIPT NO.

1964507

DIVISION

ACUTE CARE (AC)

FROM

CLINIC FOR WOMEN

STREET

3607 W 16TH ST

CITY

INDPLS

STATE IN

46222

BIRTHING CENTERS (Fund; 17610, Program: 30000, Account: 423060,

1,000.00

Department: 195129)

THUOMA

\$

1,000.00

CASH

CHECKS AND MONEY ORDERS 9011323982:

\$1,000.00

REFUND

MAIL CLERK Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

MAY 3 1 2019

RECEIVED

MAY 2 0 7413



APPLICATION FOR LICENSHIP and State Department of Health TO OPERATE AN ABORTION CLARGE Care Division in State Form 52233 (R6 / 1-19) Indiana State Department of Health-Division of Acute Care (Pursuant to IC 16-21-2 and 410 IAC 26)

Indiana State Department of Health Acute Care Division

	Division of Acu	te Care Use Only		
Date Received (mm/dd/yyyy)	_ Date Approved (mi	n/dd/yyyy)	_Date Rejected (m	m/dd/yyyy)
Please Type or Print Logibly.	SECTION I - TYPE	OF APPLICATION		
Application (Check appropriate item.)				
- 1	nge of Ownership (Antic nil a daled and signed cop	ipated date of Sale/Purc by of the bill of sale, lease	hose/Lease (mm/dd/yy or other document of	yyi) Iranšfer.
	SECTION II - IDENTI	FYING INFORMATIO	И	
A. Abortion Cilnic Location	AMO HOLLIE I I I I I I I			
Nome of Abortion Clinic				
linia For Wome	20			
Street Address (number and street) Street Address (number and street) LIOT West 16th	Street			P.O. Box
Cily		County Mario		71P Code +4 44222
100,900 1 100,900	ortlon Clinic e-mail addres ernet Web Address:_ ひ		,	
B. Mailing Address (if different from abort	on clinic location)			1.55 p.
Street Address (number and street)				P.O. Box
Cily		County		ZIP Code +4
C. Liconsee / Ownership Information				
Ligensee: The applicant entity as registered with				
Counseling of Indian	2			P.O. Box
Street Address (number and street)				T TOTAL INVENT
3407 West 16th Street		State	1.00	ZIP Code+4
Indiana polis		IN		44202
Telephone Number Fax Number	EIN	Number		al Year End Date (mm/dd)
317,955.2641 (37,90	r5 : 2487 C	51391714	/	9.131 <u> </u>

M. A. J		
D. Services provided under this license:	2 Dunillading anywant corules & Roth I and	2.
Code tiems I and 2 as follows: 1. Provided directly by emplo	byee(s), 2. Provided by a contract service, 3. bom , and	
1. Anolliary Services: Laboratory: CLIA	Certificate Number 1500871 576	Radiology Counseling
Pamily Planning	Pharmscy Cher (List):	
	y Surgical Only Both Drug In	
For item 3, indicate the total number of individuals (employee	es plus contractors) working in this clinic. This includes h	ourly, part-nine, and just-nine persons
3. Staffing: Physicians: Registered Nurs	ses: Licensed Fractical Nurses: 3	Licensed Social Workers:
Other (List title and number, do not use acronym	is): 1 Reciption is t 3 Surgical Assistants State Educato	lants 3 Medical assistants rs 1 Spanimen Tech 2. Nurse Practions
E. Number of Procedure Rooms Utilizing:		
· · · · · · · · Minimal Sedation	2. Moderale Sedation	
1		
F; Type of Entity:		
	Non-Profit .	Government
<u>For Profit</u>	Non-Profit ☐ Church Related	<u>Government</u> ☐ State
For Profit		☐ State ☐ County
For Profit Individual Pertnership	☐ Church Related	☐ State ☐ County ☐ City
For Profit individual Pertnership Corporation	Church Related Individual Parknership Comporetion	☐ State ☐ County ☐ City ☐ City/County
For Profit Individual Partnership Corporation Limited Liability Company	☐ Church Related ☐ Individuel ☐ Partnership	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
For Profit Individual Partnership Corporation Limited Liability Company Sols Proprietorship	Church Related Individual Parknership Comporetion	State County City City/County Hospital District Fisderal
For Profit Individual Partnership Corporation Limited Liability Company	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporetion ☐ Limited Hability Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
For Profit Individual Pertnership Corporation Limited Liability Company Sols Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporetion ☐ Limited Hability Company	State County City City/County Hospital District Fisderal
For Profit Individual Partnership Corporation Limited Liability Company Sols Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporetion ☐ Limited Hability Company	State County City City/County Hospital District Fisderal
For Profit Individual Partnership Corporation Limited Liability Company Sols Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporetion ☐ Limited Hability Company	State County City City/County Hospital District Fisderal
For Profit Individual Partnership Corporation Limited Liability Company Sols Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporetion ☐ Limited Hability Company	State County City City/County Hospital District Fisderal
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For Profit Individual Partnership Corporation Limited Liability Company Sols Proprietorship	☐ Church Related ☐ Individual ☐ Partnership ☐ Corporetion ☐ Limited Hability Company	State County City City/County Hospital District Fisderal

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
Otte	Zero to 799	\$500,00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000,00

410 IAC 15-5-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortlon Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH ATTENTION: CASHIER'S OFFICE, 2-C **2 NORTH MERIDIAN STREET** INDIANAPOLIS, INDIANA 46204

G. Officers of the business entity is inco Position	· Neme	_ Address	e/City/State/ZIP
President / Chairperson / CEO	LaDonna Pince	_	
Vice-President / Vice-Chairperson / COO	Sally Boonc		
Treasurer / CFO	Alisha Dunn		
Secretary	17.ta Jones		
H. Ownership and/or Change in Ownershi	ip:	· · · · · · · · · · · · · · · · · · ·	
List names end eddresses of individuals or o in the applicant entity, indirect ownership into	erest is an entity that has an ownership thich	rest in the applicant a	Hary. Ownership in any
entity higher in a pyramid then the applicant	constitutes indirect ownership. (USB enamo)	ing scient it tiecessel	y.) EIN Number
Neme	Business Address/City		
LaDonna Hinec	3/207 W. 11/4 S. In		1
Dennis Mickle	3607 W. 16th S. Inaph	3, IN 44382	35131714
	•		
f. Declarations:			
Hes any epplicant, or en owner or affiliate of and aefety concerns?			rect result of petient nearing
Has any principal or clinic staff membar bear			
Has any principal or clinic staff mamber ever administrative or legal action? YES	XT NO		
For any YES responses: attech copies of adm	inistrative and legal documentation, inspection	on reports, violetions e	end remediation contracts.
A Section of the Company of the Comp	CERTIFICATION OF APPLICATION	State of I	-desc and in summer of
The undersigned hereby makes application f this epplication, represents and shows that it with the Abortion Clinic statues, IC 16-21-2-2 maintein this clinic in accordance with those	he owner(s) and operator(s) ere of reputeble 2,5 and IC 16-34, and the rules promulgated rules.	end reesoneble che there under, 410 IAC	racter, ere eble to comply 28 end will operate and
I certify that the operational policies of the cli			
t swear and affirm under the penelty of partur complete and that I will comply with all regula	ry that all statements made in this application attentions, laws, and rules governing the licensir	n and any attachmen ng of citnics in Indiana	is thereto ere coπe⊂t end a.
Signeture of the Madical Director:	(1/10) 100		
Printed Neme and Title:	Dr. Raymond Robinson	<u>. </u>	
Dete of Signature (mm/dd/yyyy):	<u> </u>	_	
Signature of the Cijnic Administrator:	Galana Gence		
Printed Name and Title:	aDonna Prince , Din	ector	
Data of Signature (mm/dd/yyyy):	05.20.2019	1.	
See the following page for	instructions regarding lic	ensure fees a	and submission
of this application.			



Clinic for Women

3607 W 16th St, Ste B2 Indianapolis, IN 46222-2556 P: (317) 955-2641 / F: (317) 955-2687 clinicforwomen.net / Info@clinicforwomen.net

RECEIVED

MAY 2 0 7019

Indiana State Department of Health Acute Care Division

Physicians of Clinic For Women 3607 West 16th Street Ste B2 Indianapolis, IN 46222

RE: Backup Agreement

Dear

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in in I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need,

In the event my services are needed under this agreement, contact me by calling my office at

In addition, I will provide you with my cell phone and pager numbers. Please
provide the patient's name, reason for referral, current medical condition and means of transport.

A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

September 11, 2017

Details

State of Indiana		
Demographic Information		در المصابة بأدماسها
Name:	·	
Address Information		
City/State/Zip:		
County:		
License Information		 ,, ,
	Icensino Board Type: Physician seco	oṇdary:
	Expiration:	
Status: Active feared:		
Method: Application		
Discipline Information .		للرجعة المحاطنة للمراط
Discipline Internation		
Related Licenses		
Lic#: Name:		
License - Physician License Active Status:	Relationable: Same Licensee	
Specialty Information		
Specialty: Obstetrics & Gynecology (OBG)		
Documents		حو أه ميساوس بسايست
N	lo Publio Documents Avaliable	

MAY 3 1 2019

Indiana State Department of Health .
Acute Care Division

June 11, 2018

Physicians of Clinic for Women 3607 West 16th Street, Suite B2 Indianapolis, Indiana 46222

RE: Backup Agreement

Dear

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have staff privileges in at in and in . I, or one of my partners, will arrange patient admission and eare for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact the staff by calling
Please provide the patient's name, reason for referral, current medical
condition, and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

MAY 3 1 2019

Indiana State Jepartment of Flealifi Acute Crire Division

June 20, 2017

Dear

It is my pleasure to inform you that the

has approved your reappointment at . You have been reappointed to the Active entegory.

in the

Your approved clinical privileges are effective

y Your reappointment date is

Please log on to to carefully review your approved privileges for any modifications to the original submission. The instructions are attached. If you need a copy of your clinical privileges, please contact

Medical Staff members (physicians and dentists) in the Active category: if you are not currently board certified, please review of the

Sincerely,

Attachment

Physicians of Clinic For Women 3607 West 16th Street Ste B2 Indianapolis, IN 46222

RE: Backup Agreement

Dear

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in at and in I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact me by calling my office at
. In addition, I will provide you with my cell phone and pager numbers. Please
provide the patient's name, reason, for referral, current medical condition and means of transport.
A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

May 14, 2019

June 24, 2019
Randall D Snyder Division Director, Acute Care Indiana State Department of Health
RE:
Dear Sir/Madam:
are committed to the provision of quality care and are accredited Our are accredited by the engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements. Facility: Staff Appointment Date: Staff Status: Department/Section: Specialty:
If you need additional information, please contact me.
Sincerely



Eric J. Holcomb Governor

Kristina Box, MD, FACOG State Health Commissioner

June 25, 2019

Facility 011117

MEAGAN COOK
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
200 S. MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear MEAGAN COOK:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN

Genrifs Helice RN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

317/232-3095

Enclosure (1)



Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Planned Parenthood Of Indiana and Kentucky INC d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
421 S COLLEGE AVE

BLOOMINGTON, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011117-1 is effective July 1, 2019 and expires June 30, 2020.

SEAT OO BEANA

RANDALL SNYDER PT, MBA DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

07-JUN-19

RECEIPT NO. 1965443

MOISIVIG

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

AMOUNT

r

1,000.00

CASH

CHECKS AND

69343:

\$1,000.00

MONEY ORDERS

REFUND

MAIL CLERK Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

INDIANA STATE DEPARTMENT OF HEALTH

JEW 1 1 2019

MAIL MONEY RECEIPT

Acute Care Division

DATE

07-JUN-19

1965443 RECEIPT NO.

DIVISION

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

THUOMA

1,000.00

CASH

CHECKS AND

69343:

\$1,000.00

MONEY ORDERS

REFUND

MAIL CLERK Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

TIME RECEIVED June 20, 2019 3:57:47 PM EDT REMOTE CSID PPIN - Bloomington DURATION PAGES 136 4 STATUS Received

2019-06-20 15:40

PPIN - Bloomington 812 336 2402 >> PPIN

P 1/4



APPLICATION FOR LICENS! TO OPERATE AN ABORTION CLINIC

State Form 52233 (R6 / 1-19) Indiana State Department of Health-Division of Acute Cars (Pursuant to IC 16-21-2 and 410 (AC 26))

		Ì	ivision of Acu	ite Care Use O	niv	
Date Received (min	v/dd/yyyy)	Da)	e Approved (mn	v/dd/yyyy)	Date Rejec	ied (mm/dd/yyyy)
			-			
lease Type or Print	Legibly.		ECTION LATVE	OF APPLICAT	ION	
Application (Check	enamodato Ham		porton i			
• •		أمسيما	Ownership (Antice et ad end signed co.	ipated date of Sal py of the bill of sale	e/Purchoso/Lease (m), lease or other docum	uniddlyyyyi) nent of transfer.
·		SEC	TION II - IDENT	ifying inform	ATION	
A. Abortion Clinic I	ocation					
Name of Abortion Clinic	C					
Planned Parent	hood of Indian	a and ke	tucky - Bloom	nington		
Street Address (numbe	r and street)					P.O. Box
421 S. College	Avenue	•				
City				County		ZIP Code +4
Bloomington				Monroe		47403
(812) 336-0219	(812) 336-2401		Cünic e-mail ecdre	w.ppink.org	r@ppink.org	
B. Mailing Addres	e (if different from	abortion of	inic location)			
Sheet Address (numb	or and street)					P.O. Box
200 S. Meridian	1 01, 00, 400		 	County		ZIP Code +4
•				Marion		46225
Indianapolis				TAISH ISTA		
C. Licensee / Own	ership informati	on od with the o	encolant of elate			
Licensee: The applica		era was me s	amount of said			
Planned Parent						P.O. 80x
Sireet Address (num						
200 S. Meridiar	1 St., Ste. 400			State		ZIP Code+4
City				IN		46225
Indianapolie	[Cou hi	umber	EΩ	/ Numper		Fiscal Year End Date (mm/dd)
Telephone Number					74278	06/30
(317) 637-434	3 (31)	637-4	244			<u> </u>

D. Services provided under this license:		
Code tiens I and 2 as follows: I. Provided directly by emplay	su(s). 2. Provided by a connect vervice, 3. Both 1 and 2,	
		п. п
I. Ancillary Services: 1 Laboratory: CLIA	Certificate Number 1500360690	Radiology 1 Counseling
1 Hamily Planning	Plearmacy Other (List):	
I ramity Planning	Pharmacy L. Gulor (281).	
2. Abortion Services: L Drug Induced Only	Surgicul Only X Both Drug Inde	aced and Surgical
	- to a commercial sound from the other altinets. This tomberlas besse	odo navistane and full-tima nevians.
For item 3, indicate the mul number of individuals (employers	pus connuctors) एकात्रालय in uns come, 1144 माटनावस्य गुणा	the house must such that was her wants
1771	[3]	Timesed Cooled Workers
3. Staffing: Physicians: 4 Registered Nurse	8: 2 Licensed Practical Nurses: 0	Licensed Social Workers:
	Aluma Bradillaner d Appletante - 5	Admin -1
Other (List title and number, do not use acronyn s	191189 Practitional - 1, Assistanto - A	, /\dimit
E. Number of Procedure Rooms Utilizing:		
Le	Tandarata Sadatlan Z	7
Minimel Sedation LF	Moderate Sedation L2	<u></u>
F. Type of Entity:		
For Profit	Non-Profit	Government
☐ Individual	Church Related	☐ State
☐ Permership	Individual	County
☐ Corporation	Pertnership	☐ City
Limited Liability Company	☑ Corporation	City/County
Sole Proprietorahlp	Limited Liability Company	☐ Hospital District
Other (specify)	Other (specify)	☐ Federal
		Other (specify)
		•
l		

G. Officers (if the business entity is inco	more	ed)	
Poeltlon	1	Name	Address/Cily/State/ZIP
President / Cheirperson / CEO	Don	na Kerr	200 8 Maridian St. Ste. 400 Indianapolis IN 46226
Vice-President / Vice-Chairperson / COO	Kris	ten Roby Dimlow	200 S Meridian St. Sto. 400 Indianapolis IN 46225
Treasurer / CFO	Ter	l Pickens Manweil	209 S Meridian St. Ste. 400 Indianapolis IN 46225
Secretary	Tua	n Ngo	200 S Meridian St. Ste. 400 Indianapolis IN 46225
H. Ownerehip end/or Changa in Ownersh List names and addressee of individuels or o in the applicant entity, indirect ownership intentity higher in a pyramid than the applicant	rganiz	AN ANIMY THAT THE BIT DWITE STATE IN 1919	nip or controlling interest of five percent (5%) at in the applicant entity. Ownership in any at these if nacressary.)
entity higher in a pyramic than the applicant Name	COURT	Business Address/City/8	State/ZIP EIN Number
(Value			
		· · · · · · · · · · · · · · · · · · ·	
I. Declarations:		et a state of the	tives depend as a direct result of opiont basis
and safety concerns? LIYES MINO			n wae closed as a direct result of paliant health
Has any principal or clinic staff mamber bee	n conv	cted of a felony? YES NO	ab the state of th
Hae eny principal or clinic stall member eve administrative or legal action? YES	I MATERIAL	o T	
For any YES responses: ettech copies of ad	ninistre	ive and legal documentation, inspection	n reports, violations and remediation contracts.
		ERTIFICATION OF APPLICATION	t the first of the first and in support of
	(na owi 2,5 en:		inio) in the State of Indiana, and in support of end reasonable character, are able to comply there under, 410 IAC 26 and will operate and
I certify that the operational policies of the o	linic wi	not provide for discrimination based (upon rece, color, creed, or netionel origin.
I ewear and affirm under the penalty of peri- complete and that I will comply with all regu	me that	olizatione sist of sham stremeters for	n and any attachmente thereto are correct and
Signature of the Medical Director:		a	
Prinled Name and Title:	Deb l	ucatola, Medical Director	•
Dete of Signalure (mm/dd/yyyy):		6/21/19	
Signature of the Clinic Administrator:	M	ungan Golf	
Prinled Name and Title:	Meag	an Cook, Health Center Mana	ger
Date of Signature (mm/dd/yyyy):		16-20-2019	
	<u>r ins</u>	tructions regarding lic	ensure fees and submission
of this application.			

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

410 IAC 15-5-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mall to:

INDIANA STATE DEPARTMENT OF HEALTH ATTENTION: CASHIER'S OFFICE, 2-C 2 NORTH MERIDIAN STREET INDIANAPOLIS, INDIANA 46204

JUN 1 1 2019



APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC

State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acute Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

Indiana State Department of Health Acute Care Division

		Division of	Acute Care Use O	ylv	
Date Received (mm	/dd/yyyy)	Date Approved	(nım/dd/yyyy)	Date Rejected (mn	n/dd/yyyy)
Please Type or Prin	t Lealbly.				
THE STATE OF THE S	37	SECTION I -	TYPE OF APPLICAT	ON	
Application (Check	appropriale ilem.		-		
☐ New Facility 🗵	Renowal S] Changé of Ownership (# ubmit a dated and signed o	Anticipated date of Sale opy of the bill of sale, lea	r/Purchäse/Lesse (mm/dd/yyy se or other document of trans	y))
		SECTION II - ID	ENTIFYING INFORM	ATION	
A, Abortion Clinic I	ocation				
Name of Abortion Clinic					
Planned Parenthood o	of Indiana and Kentu	icky - Bloomington			P.O. Box
Street Address (number	ir and streot)				
421 S. College			County		ZIP Code +4
Clty			Monroe		47403
Bloominigon Telephone Number	Fax Number		SOMOM		
(812) 336-0219	(812) 336-2401			oink.org	
C Station Adding	e (if different from	abortion clinic location)			
Street Address (numb	er and street)	abortion oiline to access			P.O. Box
200 S. Meridian Stree City	I, Suite 400		County		ZIP Code +4
1			Marion		46225
Indianapolis			MRHAI		1
C. Licensee/Owno	rsnip intormatio	n ed with the secretary of sta	te		
1 '			•		
Planned Parenthood Street Address (numi	ber and street)	ucny, into.			P.O. Box
200 S. Meridian Sulto	400		State		ZIP Code+4
City			Indiana	•	46225
Indianapolis Telephone Number	Fax N	imper	EIN Number	Fisc	al Year End Date (mm/dd)
1			35-08	74276	06/30
(317) 637-4343	(317) 637-4344	<u> </u>		

D. Services provided un	nder this license:		
Code items 1 and 2 as follows:	1. Provided directly by employe	e(s), 2. Provided by a contract service, 3. Both 1 and	12.
1. Ancillary Services:	Laboratory: CLIA Co	ertificate Number 1500566690	Radiology Counseling
1	Family Planning	Pharmacy Other (List):	<u>.</u>
2. Surgical Services:	Gynecology	Other (List):	•
For item 3, indicate the total nu	nber of individuals (employees pl	us contractors) working in this clinic. This includes he	ourly, part-time, and full-time persons.
3. Staffing: Physicians:	Registered Nurses:	Licensed Practical Nurses:	
Li	censed Social Workers:	Other (List title and number):	Nose Practioner-1.
E. Number of Procedu	re Rooms Utilizing:		- -
	<i>তি</i> ।	A Landa Comparison Controller (7
Local analgesia/ane:	sthetic [Moderate/Conscious Sedation	
Local analgesia/ane	sthetic LG	Moderate/Conscious Segation L	
	sthetic LG	Non-Profit	Government
F. Type of Entity:	sthetic LE	· · · · · · · · · · · · · · · · · · ·	
F. Type of Entity:	sthetic L	Non-Profit	Government
F. Type of Entity: For Profit Individual	sthetic L	Non-Profit Church Related	Government State
F. Type of Entity: For Profit Individual Partnership		Non-Profit Church Related Individual	Government State County
F. Type of Entity: For Profit Individual Partnership Corporation		Non-Profit Church Related Individual Partnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company		Non-Profit Church Related Individual Partnership Corporation	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sola Proprietorship		Non-Profit Church Related Individual Partnership Corporation Limited Liability Company	Government State County City City/County Hospital District
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	Name		Add	Address/Cliy/State/ZIP	
President/Chalrperson/CEO	Oonna	Kerr		200 South Meridian, Suite 400 Indianapolis, IN 46225	
Vice-PresidenWice-Chairperson/CO	Kristen	Roby Dimlow	200 South Meridia	200 South Meridian, Suite 400 Indiarapolis, IN 46225	
Treasurer/CFO	Terri Pi	ckens Manwell		200 Sorth Meridian, Suite 400 Indianapolls, 1N 46225	
Secretory	Tuan Ngo			200 South Meridian, Suite 400 Indianapolis, IN 46225	
H. Ownership and/or Change in Owner List names and addresses of Individuals of in the applicant entity, India- ot ownership i	organization	entity that has an ownership	p interest in the applicant	entity. Ownership in any	
entity higher in a pyramid than the applicar	t constitutes			y.) EIN Number	
Name		Business Addres	BACITY/SIBIEIZIP	EIN NUMBER	
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	CERT				
		ification of applicat			
The undersigned hereby makes application his application, represents and shows the with the Abortion Clinic statues, IC 16-21-2 maintain this clinic in accordance with the certify that the operational policies of the swear and affirm under the panelty of periomplete and that I will comply with all regular	n for elicens the owner(s -2.5 end IC le rules. clinic will n iny that all st	e to operate an Abortion Cit) and operator(s) are of repr 16-34, and the rules promule of provide for discrimination at ements made in this oppli	nic (CEnic) in the State of viable and reasonable of gated there under, 410 l/ n based upon rece, colo caton end any attachmen	aracter, are able to comply C 26 and will operate and r, creed, or notional origin.	
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License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
Х	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000,00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. O. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



200 South Meridian Street Suite 400, Indianapds, IN 46225
Mailing Address: P.O. Box 397, Indianapolis N46206-0397
p:317.637.4343 · t;317.637.4344
www.ppintorg

Planned Parenthood of Indiana and Kentucky

February 25, 2019

Planned Parenthood of Indiana and Kentucky 421 S College Ave Bloomington, IN 47403

Re: Backup Agreement for Monroe County

Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency, or other medical need that requires hospitalization.

I have admitting privileges at in , Indiana. As needed outside of usual eare practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of eare, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. Acopy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any rea son.

Sincerely.

JUV 1 1 2019

Indiana State ___ syment of Health Acute Care Division

August 23, 2017

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical
Privileges to
, which includes and
, have been approved by the Board of
member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of !patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to earry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

November 07, 2018

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical
Privileges to , which includes , and
, have been approved by the Board of
Directors for to as a member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

June 27, 2018

RE: Membership and Clinical Privileges

Dear .

I am pleased to inform you that your Application for Reappointment and Request for Clinical which includes , i and the have been approved by the Board of Directors for to as a. member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of I patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

June 24, 2019	
Randall D Snyder Division Director, Acute Care Indiana State Department of Healt	h ·
RE:	
Dear Sir/Madam:	
focused professional practice evaluation competency - patient care, medica interpersonal and communication	are committed to the provision of quality care and are accredited. Our the nagement activities, ongoing professional practice evaluation and uation. We monitor our practitioners in six areas of general al/clinical knowledge, practice-based learning and improvement, skills, professionalism, and systems-based practice. e necessary requirements to maintain clinical privileges and al/Allied Health Staff including professional, moral, ethical and
Facility: Staff Appointment Date: Staff Status: Department/Section: Specialty:	
If you need additional information	, please contact me.
Sincerely,	

.

June 24, 2019

Randall D Snyder Division Director, Acute Care Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited
Our

are accredited by the
engage in peer review, quality management activities, ongoing professional practice evaluation and
focused professional practice evaluation. We monitor our practitioners in six areas of general
competency - patient care, medical/clinical knowledge, practice-based learning and improvement,
interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and
membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and
physical requirements.

Facility:

Staff Appointment Date:

Staff Status:

Department/Section:

Specialty:

If you need additional information, please contact me.

June 24, 2019	
Randall D Snyder Division Director, Acute Care Indiana State Department of Health	
RE:	
Dear Sir/Madam:	
are accredited by the engage in peer review, quality manage focused professional practice evaluate competency - patient care, medical/conterpersonal and communication skills.	re committed to the provision of quality care and are accredited. Our We gement activities, ongoing professional practice evaluation and tion. We monitor our practitioners in six areas of general elinical knowledge, practice-based learning and improvement, ills, professionalism, and systems-based practice. Recessary requirements to maintain clinical privileges and willied Health Staff including professional, moral, ethical and
Facility: Staff Appointment Date: Staff Status: Department/Section: Specialty:	
If you need additional information, pl	ease contact me.
Sincerely	

the second second

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Erle J. Holcomb Governor

Kristina Box, MD, FACOG State Health Commissioner

June 25, 2019

Facility 011118

TAJUANA BYRD
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
200 S; MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear TAJUANA BYRD:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN

Gennifs Hedre RN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

317/232-3095

Enclosure (1)



Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Planned Parenthhod Of Indiana and Kentucky d/b/a PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC 8590 GEORGETOWN RD

INDIANAPOLIS, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011118-1 is effective July 1, 2019 and expires June 30, 2020.

RANDALL SNYDER PT, MBA DIRECTOR, ACUTE CARE DIVISION

State Form 448-10 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

06-JUN-19

RECEIPT NO.

1965424

DIVISION

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

AMOUNT

....

9

1,000.00

CASH

CHECKS AND

69341:

\$1,000.00

MONEY ORDERS

REFUND

MAIL CLERK Wade, Amber

REMARKS

INDPLS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

06-JUN-19

RECEIPT NO.

1965424

DIVISION

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

ÇITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

RECEIVED

JUN -7 2019

Indiana State Department of Health Acute Care Division

AMOUNT

1,000.00

CASH

CHECKS AND

69341:

\$1,000.00

MONEY ORDERS

REFUND

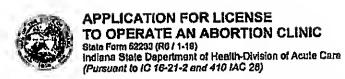
MAIL CLERK Wade, Amber

REMARKS

INDPLS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1



		Division of Acut	e Care Use Only	
Date Received (mm/dd/yyyy) Date Approved (mn			dd/yyyy)	Date Rejected (mm/dd/yyyy)
ease Type or Print	Lealbly.			·
cudo 17po or 11no		SECTION 1-TYPE	OF APPLICATION	
Application (Check	appropriate (lem.)			
New Facility	Renewal	Change of Ownership (Anticip Submit a dated and signed copy	eated date of Sale/Pu of the bill of sale, lea	rchase/Lease (mm/dd/yyyy)) se or other document of transfer.
		SECTION II - IDENTIF	YING INFORMATI	ON
A. Abortion Clinic	Location			
Name of Abortion Clint				
		a and Kentucky - Indiana	apoils	P.O. Box
dmun) ecorbbA toorli				P.O. BOX
8590 Georgeto	wn Road			ZIP Code +4
City			County	46268
indianapoils			Marion	40200
Telaphone Number (317) 872-3115	Fax Number (317) 872-3118	Abortion Cilnic e-mail eddress	; annjeanettebo	ottoms@ppink.org
		Internet Web Address: WWW	y,ppink.org	
R Mailing Addres	s fit different from	abortion clinic location)		
Street Address (numb	er and street)			P.O. Box
200 S. Meridiar		ino		
City	t Ouest, Outer		County	ZIP Cada +4
			Merlon	46225
Indianapolis			1	Li.
C. Licensee / Owr	rership informetic ant entity og registere	d with the secretary of state		
		a and Kentucky, INC.		
Street Address (num				P,O, Box
200 S. Meridlar		100		
City			State	ZIP Code+4
indianapolis			IN	46225
	Fau No	and an all selections	Viimbar	Fiscal Yeer End Date (mm/dd

EIN Number

35-0874276

06/30

Fax Number

(317) 637-4344

Telephone Number

(317) 637-4343

D. Services provided under this license:							
Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.							
	Certificate Number Other (List):	Radiology Counseling					
	Surgical Only Both Drug Inc						
For item 3, indicate the total number of individuals (employees)	plus contractors) working in this clinic. This includes ho	urly, part-time, and full-thne persons,					
3. Steffing: Physicians: 9 Registered Nurse	s: 2 Licensed Practical Nurses: 0	Licensed Social Workers:					
Other (List title and number, do not use acronyms)	li						
E. Number of Procedure Rooms Utilizing:							
Minimal Sedation 2 Moderate Sedation 2							
Minimal Sedation 2	Moderate Sedation L	2					
Minimal Sedation 2 F. Type of Entity:	Moderate Sedation L	<u>2</u>]					
	Moderate Sedation L Non-Profit	Coveragent					
F. Type of Entity: For Profit	1 Modelate Occasion 2						
F. Type of Entity: For Profit Individual	Non-Profit	<u>Government</u>					
F. Type of Entity: For Profit	Non-Profit Church Related	Government State					
F. Type of Entity: For Profit Individual Parinership	Non-Profit Church Related Individual	Government State County City City City/County					
F. Type of Entity: For Profit Individual Partnership Corporetion	Non-Profit Church Related Individual Partnership	Government Slate County City City/County Hospital District					
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company	Non-Profit Church Related Individual Partnership Corporation	Government State County City City/County Hospital District					
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	Name		Address/City/State/ZIP	
President / Chairperson / CEO	Donna Kerr	200 S. Maridian St., Ste 400 Indianapolis, IN 4822		
Vice-President / Vice-Chairperson / COO	Kristen Roby Dimlow	200 S. Maridian St., Sia 400 Indianapolis, IN 46225		
Treasurer / CFO	Tern Pickens Manweil	200 S. Meridian St., Ste 400 Indianapolis, IN 462		
Secretary	Tuan Ngo	200 S. Meridian St.	Ste 400 Indianapolis, IN 482	
Ownership and/or Change in Ownershist nemes and addresses of individuals or of the applicant entity. Indirect ownership intentity higher in a pyramid then the applicant	rganizations having direct or indirect o	i Mielest ill me abbicant i	stitity. Omijeretily in dily	
Nama	Business Addres	e/City/State/2IP	EIN Number	
			-	
Declarationa:		<u> </u>		
as any applicant, or an owner or affiliate of deelety concerns?			direct result of patient he	
		766		
		THO	alamad on a social of	
ae any principal or clinic etaff member evel dministrativa or legal action? YES	remployed by a facility owned or open	ated by the epplicant that		
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License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
0110	Zero to 799	\$500.00
- _v —	800 to 3,499	\$1,000.00
_ ~	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

410 IAC 15-5-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or

(B) A copy of:

- (1) his/her written agreement with another physician with admitting privileges; and
- (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH ATTENTION: CASHIER'S OFFICE, 2-C 2 NORTH MERIDIAN STREET INDIANAPOLIS, INDIANA 46204



APPLICATION FOR LICENSE
TO OPERATE AN ABORTION CLINIC
State Form 52233 (R3 / 3-14)
Approved by State Board of Accounts, 2014
Indiana State Department of Health-Division of Acuta Care
(Pursuant to IC 16-21-2 and 410 IAC 26)

		Division of Ac	ute Care Use O	nly	
Date Received (mm/dd/yyyy) Date Appro			Dele Approved (mm/dd/yyyy) Dele Rejected (i		
Please Type or Prin	t Legibly.		PE OF APPLICATI	ON	
		SECTION 1 - 141	PE OF APPLICATI	ON	
Application (Check		Change of Ownership (Anii mit a detad and signad copy	cipated data of Said of the bill of sale, lea	/Purchase/Loase (m so or Olhor documen	midd/yyyy)) i of transfer.
		SECTION II - IDEN	TIFYING INFORM	ATION	
A. Abortion Clinic L Name of Abortion Clinic Planned Parenthood o	f Indiana and Kentuc	ky - (ndianapolis			P.O. Box
Street Address (number					
8590 Georgelown Ros	ad		County		ZIP Code +4
Indianapolis			Marion		46268
Telephone Number (317) 872-3115	Fax Numba <i>r</i> (317) 672-3116	Abortion Clinic a-mail addr Intamet Wab Addrass; wa		loms@ppink.თ <u>ი</u>	
B. Mailing Addres	s (if different from t	abortion clinic location)			P.O. Box
Street Address (numb	er and street)				
200 S. Meridian Stree City	t, Suita 400		County		ZIP Code +4
Indianapolis			Marion		46225
C. Licensee/Own Licensea: The applic	ant entity aa registere	d with the secretary of state			
Plannad Parenthood Street Address (num	ber and street)	sky, INC.			P.O. Box
200 S. Meridian Suite	400		Stata		ZIP Code+4
City			Indiana		46225 Fiscal Year End Date (mm/dd)
Indianapolis Telaphone Number	Fax Nu	mber E	IN Number 35-08	74276	06/30
(317) 637-4343					

s licenses	-
	and 2
ded directly by emphyrods). A crowned by a contract service. I have	
aboratory: CLIA Certificate Number 1500360690 amily Planning Pharmacy Other (List):	Radiology Counseling
Synecology Other (List): Individuals (employees plus contractors) working in this clinic. This include Registered Nurses: Licensed Practical Nurses: Other (List title and manhe)	es hanely, part time, and full-time persons.
oms Utilizing: Moderate/Conscious Sedation	n 2
Non-Profit	Government
☐ Church Related ☐ Individual ☐ Partnership ☑ Corporation ☐ Limited Liability Company ☐ Other (specify)	State County City City/County Hospital District Federal Other (specify)
	amily Planning

Position	Name	Addre	sa/City/State/ZiP	
President/Chekperson/CEO	Donna Kerr	209 South Meridian. S Indianopolis, 1N 4622		
Vice-PresidenWice-Chelrperson/COO	Kristen Roby Dimlow	200 Somb Meridian, S Indinospolis, IN 4622		
Tressurer/CFO	Terri Pickens Manwell	200 South Meridian, 9 Indianapolia, IN 4622		
Secretary	Tuan Ngo	200 South Meridian, 5 Indianopolis, IN 4622		
d. Ownership and/or Change in Owners list names end addresses of individuals or on the epplicant entity, indirect ownership in	riganizationa having direct or indire	nind interest in the addacable is	ITITA' CHUIGINITH III MIL	
entity higher to e pyramid than the applicant	constitutes indirect ownership. (Us	e eddillonal sheet if necessa.y. dress/Cky/State/ZIP	EiN Number	
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The undersigned hereby makes application his epplication, represents and shows that the him the Abortion Clinic stetues, IC 18-21-2-naintain this clinioin eccordance with those certify that the operational policies of the awear and effirm under the penalty of perjubomplete and their will comply with eli regular	he owner(s) end operator(s) are 0 2.5 and IC 18-34, and the rulos pro a rules. clinic will not provide for discrimin or that of statements made in this s	reputable and reasonedie cha imulgated there under, 410 IAC lation based upon race, color, accilcation and any eliachment	craed, or national original three or care conceins or national original three or conceins or care conceins o	
Signeture of the Medical Director:)			
Printed Name and Title:	Vucatola McCleal Director			
Date of Signature (mmkddyyyy.l:	2019			
signature of the Clinio	Quanak-Brol			
Printed Neme end Title:	me Byrd, Houlth Certer Mahager			
Date of Signalure (mmiddlyyyyJ:	1019			

January 15, 2019

Dear

It is my pleasure to inform you that the

has approved your reappointment at

in the

. You have been reappointed to the Active category.

Your approved clinical privileges are effective

. Your reappointment date is

Please log on to to carefully review your approved privileges for any modifications to the original submission. The instructions are attached. If you need a copy of your clinical privileges, please contact or !.

Medical Staff members (physicians and dentists) in the Active category: If you are not currently board certified, please review of the

Sincerely,

Attachment

June 27, 2018

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to which includes and have been approved by the Board of Directors for to as a member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Februery 16, 2018

Deer

I am heppy to notify you that the Board of Directors, on the recommendation of the Medical Staff, has epproved your reappointment to the medical staff of North. Your reappointment period is effective from through

A current copy of your delineation of privileges is enclosed.

The Board of Directors, Medical Steff and Administration eppreciate your continued service to the hospital. If you have any questions please contect the Medical Steff Office at

November 07, 2018

RE: Membership and Clinical Privileges

Dear

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to which includes and have been approved by the Board of Directors for to as a member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of patients; families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to earry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Stuff Services Office at the number below.

December 21, 2018

RE: Reappointment of privileges

Dear

Please allow this letter to confirm with you that the of the Board of Directors, has accepted a recommendation from the Medical Executive Committee to continue your membership and clinical privileges. Your reappointment period is from to

As a member of the Medical Staff, you are expected to fulfill all requirements set forth in the Bylaws, Rules and Regulations and Policies and Procedures and to keep all records up to date. Bylaws are located on the Medical Staff Office at

Reappointment to the Medical Staff is contingent upon your maintaining the prescribed standards of the Bylaws and approved Medical Staff policies.

The Board of Directors, Medical Staff, and Administration appreciate your continued service to the hospital. Please contact the Medical Staff Office at if you have any questions.

August 23, 2017

RE: Mombership and Clinical Privileges

Dear :

l am pleased to inform you that your Application for Reappointment and Request for Clinical which includes and have been approved by the Board of Directors for to as a member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of . , families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of . Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

June 24, 2019

Randali D Snyder Division Director, Acute Care Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited Our.

are accredited by the
engage in peer review, quality management activities, ongoing professional practice evaluation and
focused professional practice evaluation. We monitor our practitioners in six areas of general
competency - patient care, medical/clinical knowledge, practice-based learning and Improvement,
interpersonal and communication skills, professionalism, and systems-based practice.
The above practitioner has met the necessary requirements to maintain clinical privileges and
membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and
physical requirements.

Facility:

Staff Appointment Date:

Staff Status:

Department/Section:

Specialty:

if you need additional information, please contact me.

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited

are accredited by the ... We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:

Staff Appointment Date:

Staff Status:

Department/Section:

Specialty:

If you need additional information, please contact me.

Print this Page

Medical Staff Membership or Affiliation

06/24/2019

Randail D Snyder Division Director Indiana State Department of Health

Re:

Is committed to the provision of quality care and is accredited by the . We engage in quality review activities for the purpose of concurrent and retrospective data collection, review and reporting. We continually monitor and evaluate the care our staff provides, including complication and mortality rates, number of admissions and procedures, peer review findings from drug usage evaluation, surgical case review, transfusion review, medical records review and departmental review, along with other indicators of the quality of care.

The practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medicai/Dental/Ailied Health Staff including professional, moral, ethical and physical requirements.

Entity Name:

Staff Appointment Date:

Staff Status:

Department:

Category: Current

Credentialed From Date: Credentialed To Date:

Entity Name:

Staff Appointment Date:

Staff Status: Active

6/24/2019

Department:

Category: Current

Credentialed From Date:

Credentlaled To Date:

Should you require additional information or if you have questions, please contact the Medical Staff Services Department at

Print this Page

Medical Staff Membership or Affiliation

06/24/2019

Randall D Snyder Division Director Indiana State Department of Health

Re:

Is committed to the provision of quality care and is accredited by
the . We engage in quality review activities for the purpose of concurrent
and retrospective data collection, review and reporting. We continually monitor and evaluate
the care our staff provides, including complication and mortality rates, number of admissions
and procedures, peer review findings from drug usage evaluation, surgical case review,
transfusion review, medical records review and departmental review, along with other
indicators of the quality of care.

The practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Entity Name:

Staff Appointment Date: 1

Staff Status: Active

Department:

Category: Current

Credentialed From Date: Credentialed To Date:

Entity Name:

Staff Appointment Date:

Staff Status:

6/24/2019

Department:

Category: Current

Credentialed From Date: .

Credentialed To Date: ;

Should you require additional information or if you have questions, please contact the Medical Staff Services Department at

Sincerely,

2/2



Eric J. Holcomb

Kristina Box, MD, FACOG State Health Commissioner

June 25, 2019

Facility 013765

KALILA WEINER PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC -200 S. MERIDIAN STREET, SUITE 400 INDIANAPOLIS, IN 46225

Dear KALILA WEINER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN

Gennifes Hebre EN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

317/232-3095

Enclosuré (1)



Indiana State Department of Health

Abortion Clinic License

This is to certify that:

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC - LAFAYETTE d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC 964 MEZZANINE DR
LAFAYETTE, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-013765-1 is effective July 1, 2019 and expires June 30, 2020.

STATE OF STA

RANDALL SNYDER PT, MBA DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIFT

DATE

06-JUN-19

RECEIPT NO.

1965423

DIVISION

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

500,00

Account: 423010, Department: 195129)

AMOUNT

\$

500.00

CASH

CHECKS AND

69342:

\$500.00

MONEY ORDERS

REFUND

MAIL CLERK Wade, Amber

REMARKS

LAFAYETTE

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

06-JUN-19

RECEIPT NO.

1965423

DIVISION

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

500.00

Account: 423010, Department: 195129)

RECEIVED

JUN - 7 2019

Indiana State Department of Health Acute Care Division

AMOUNT

500.00

CASH

CHECKS AND

69342:

\$500,00

MONEY ORDERS

REFUND

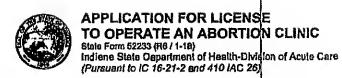
MAIL CLERK Wade, Amber

REMARKS

LAFAYETTE

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1



Division of Acute Care Use Only							
Date Received (mn	n/dd/yyyy)	Da	te Approved (mm/dd/yyyy) Date Rejected (mm/dd/yyyy)				
,							
Please Type or Print Legibly.							
SECTION I - TYPE OF APPLICATION							
Application (Check appropriate item.)							
New Facility	Renewal	Chenge o	Ownership (Ar	nticipeted date of Sale/Put I copy of the bill of sale, lea	irchase/Lease (mm/dd ise or other document	Vyyyy)) of transfer.	
		SUDJUIT B C	aren aun siliten	OUP OF THE DIS OF GOIS, TOD	AT AT ANIES MARKETINGS		
		SE	TION II - IDE	NTIFYING INFORMATI	ON		
A. Abortion Clinic L	ocation						
Name of Abortion Clinic				· · · · · · · · · · · · · · · · · · ·			
Plannad Parentl	hood of India	ına and Ke	ntucky - Lai	fayette			
Street Address (number		·				P.O. Box	
964 Mezzanine	Driva						
City				County		ZIP Code +4	
Lafayetta				Tippacanoe		47905	
Telephone Number	Fax Number						
(765)	(765)		Clinic e-mail eddress: maritza.torres@pplnk.org				
286-3701	446-8160	Aportion	P#⊔IC 6-11/89 600	21000:	- Inflation of the second		
						.]	
		Internet \	Veb Address: V	ww.ppink.org	<u> </u>		
	41F -1166 A #		nio localieni				
B. Mailing Address Street Address (number		m Boonion Ci	no location)			P.O. Box	
200 S. Meridlan	St., Ste. 400	<i>.</i>		County		ZIP Code +4	
City						46225	
Indianapolis	, <u></u>		Marton 46225			10220	
C. Licensee / Own	ership informa	tion	raceluse of etoto				
Licensee: The epplica	mi entity as regist	Bled Will tile &	mercially of state				
Plannad Parent		ma ano re	intucky, live			P.O. Box	
Street Address (numb		1					
200 S. Mandian	St., Ste. 400	J	 -	State		ZIP Code+4	
City Indianapolis				IN		46225	
Telephone Number	Fax	Number	+	EIN Number	F	iscal Year End Dete (mm/dd)	
(317) 637-434	1	17) 637-43	344	35-08742	276	06/30	
(311) 031-434	1 1 1	., 50, 40	· · · · · · · · · · · · · · · · · · ·	***			

D. Services provided under this license:		
Code items 1 and 2 as follows: 1. Provided directly by en	 playee(s), 2. Provided by a contract service, 3. Both 1 am	d 2.
t. Ancillary Services: 1 Laboratory: CL	A Certificate Number 1500360690	Radiology Counseling
1 Family Planning	Pharmacy Other (List):	,
2. Abortion Services: X Drug Induced Or	ly Surgical Only Both Drug to	aduced and Surgical
For item 3, indicate the total number of individuals (employ	es plus contractors) working in this clinic. This includes h	ourly, part-time, and full-time persons.
3. Staffing: Physicians: 3 Registered Nu	ses: 0 Licensed Practical Nurses: 0	Licensed Social Workers:
Other (List title and number, do not use acrony.	rs):	
E. Number of Procedure Rooms Utilizing		
Minimal Sedation	0 Moderate Sedation	0
	<u> </u>	
F. Type of Entity:		
F. Type of Entity: For Profit	Non-Profit	Government
	Non-Profit ☐ Church Related	Government
For Profit		
For Profit Individual	Church Related	☐ State ☐ County ☐ City
For Profit Individuat Partnership Corporation Limited Liebility Company	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation	State County City City/County
For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
For Profit Individuat Partnership Corporation Limited Liebility Company	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation	State County City City/County Hospital District
For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospital District
For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	State County City City/County Hospital District
For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	State County City City/County Hospital District
For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	State County City City/County Hospital District
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For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	State County City City/County Hospital District
For Profit Individuat Partnership Corporation Limited Liebility Company Sole Proprietorship	☐ Church Related ☐ Individuat ☐ Pertnership ☑ Corporation ☐ Limited Liebility Company	State County City City/County Hospital District

G Officers (if the husiness entity is income		reled)		
G. Officers (if the business entity is incorport Position		Name Name	Address/City/State/ZIP	
President / Chelrperson / CEO	D	onna Kerr	200 S, Meridian St. Ste. 400 Indianapolis, IN 46225	
Vice-President / Vice-Chelrperson / COO	К	risten Roby Dimlow	200 S, Meridian St, Ste. 400 Indianapolis, IN 46225	
Treasurer / CFO	T	erri Pickens Manwell	200 S. Meridian St. Ste. 400 Indianapolis, tN 46225	
Secretary	T	uan Ngo	200 S, Maridian St. Sta. 400 Indianapolis, IN 48225	
H. Ownership and/or Change in Ownersh List names and addresses of Individuale or	orge	izations heving direct or Indirect ownership	or controlling interest of five percent (5%)	
In the epplicant entity. Indirect ownership intentity higher in a pyramid than the applicant	cons	is an entity thei has an ownership interest stitutes indirect ownership. (Use additional	In the applicant antity. Ownership in eny sheat if nacessary.)	
Neme		Businese Address/City/Sta		
•				
i. Declerations:			I a a disease consist of a cilent breath	
Hea any applicant, or an owner or affiliate of and selety concerns?	f tha	applicant, oparated an ebortion clinic that w	vas closed as a direct result of petiant haelth	
Has any principel or clinic staff member bee				
Hes any principel or clinic staff member eve edministrativa or legal ection? YES		ŅO		
For any YES responses: attach copies of adi	ninis	rative and legal documentation, inspection r	reports, violetions and remediation contracts.	
		CERTIFICATION OF APPLICATION	o) in the State of Indiana, and in support of	
The undersigned hereby makes application this application, raprasents and shows that with the Abortion Clinic statues, iC 16-21-2-maintain this clinic in accordance with those	the o 2,5 e	hmar(a) end operator(a) ere of reputable and the rules promuigated the	nd masonable clistscist, dia sola lo comply	
I cartify that the operational policies of the c	inic i	villi not provide for discrimination based upo	on raca, color, creed, or netional origin.	
I sweer and affirm under the penelty of perju complate and thet I will comply with all ragu	ury th lettor	at all atatements mede in thie epplication e is, laws, end rules governing the licensing o	end eny ettachmants thereto are correct end of clinics in Indiena.	
Signature of the Madical Director:		a		
Printad Name and Title:	Det	Nucatola, Medical Director		
Date of Signature (mm/dd/yyyy):		6/21/19		
Signature of the Clinic Administrator:	R	alla Muner	HCM	
Printed Neme and Titla:	Kal	lla Weiner, Health Center Manager		
Data of Signature (mm/dd/yyyy):	Ω,	9/20/19	for and submission	
	<u>r in</u>	structions regarding lice	nsure fees and submission	
of this application.				

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
~	Zero to 799	\$500.00
	800 to 3,499	\$1,000,00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

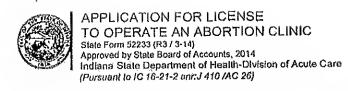
410 IAC 15-5-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH ATTENTION: CASHIER'S OFFICE, 2-C 2 NORTH MERIDIAN STREET INDIANAPOLIS, INDIANA 46204



		Division of Acu	te Care Use Only	,		
Date Received (mmlddlyyyy)Date Approv		Date Approved (mm	proved (mmlddlyyyy)Date Rejected		n/dd/yyy y),	
Please T‴e orf	Print Legib/v.	COCHON I PVE	PE OF APPLICATION			
A No - House /Class	-th appropriate Ham		E OF AFFLICATION			
Application (Check appropriate Item.) D New Facility Renewal D Change of Ownership (Anticipated date of Sale/Purchase/Lease (mmlddlyyyy)) Submit a dated and signed copy of the bill of sale, lease or other document of transfer.						
		SECTION II - IDENTI	FYING INFORMATION			
A. Abortion Clini Name of Abortion Clini Planned Perenthöo						
Street Address (no 964 Mezzanine Drive		· · · · · · · · · · · · · · · · · · ·			P.O. Box	
City Lafayette	1				ZIP Code +4 47905	
Telephone Number	Fax Number (317)872-3118	Abortion Clinic e-mail addre				
	f	Internet Web Address:	www.ppink.org		,	
8. Malling Addres	s (if different from a	abortion clinic location)				
Street Address (nui	nber and street)				P.O. Box	
200 South Meridia City	n, Suile 400		County		ZIP Code +4	
Indianapolis			Marion		46225	
Licensee: The app		ed with the secretary of state				
Street Address (nui		ky, INC			P.O. Box	
City	n Street, Suite 400		Slate		ZIP Code+4	
Indianapolis			Indiana	Flace	46225 at Year End Date (mmldd)	
Telephone Number (317) 637-4344	Fax Nu (317) 6	mber 37-4344 EIN	Number 35-0874276	06/3		

D. Services provided under this lice	ense:					
Code tivus 1 and 2 as follows: 1. Provided di	recily by employeets). 2. Provided by a contract service. 3. Both	I and 2				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	y Planning Pharmacy Other (List):	Radiology Counseling				
Famil	y ranning rearranty oner pany	2 1 199 rations 1 0 1 0 4 019 promised 1				
For item 3, indicate the mol number of indival	nuls temployees plus contractors) working in this clinic. This inclin	des honels, part-time, and full-time persons.				
3, Staffing: Physicians: 3 Reg	istered Nurses: O Licensed Practical Nurses:					
Licensed Social Workers: Other (List title and number): (Ass. title and						
E. Number of Procedure Rooms	. Utilizing:					
Local analgesia/anesthelic Moderate/Conscious Sedation 0						
F. Type of Entity:						
For Profit	Non-Profit	Government				
☐ Individual	Church Related	☐ State				
Partnership	Individual	County				
Corporation	Partnership	City				
Limited Liability Company	☑ Corporation	City/County Haspitel District				
Sole Proprietorship	Limited Liability Company	La Mashira District				
		☐ Federal				
Other (specify)		Giher (specify)				
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Position .	Name	Addre	ess/Chy/State/ZIP
President/Chalrperson/CEO	Donna Kerr	200 Semi Meridian. Indianapolis, IN 462	
Vice-PresidenWice-Chairperson/COO	Kristen Roby Dimlow	200 South Meridian. Indianapolis, 1N 462	Sidto 400
Treasurer/CFO	Terri Pickens Manwell	200 South Meridian, Indianapolis, IN 462	
Secretary	Tuan Ngo	200 South Meridian. Indianapolis, IN 462	
H. Ownership end/or Change in Ownersh			
List names and addresses of individuals or o in the applicant entity, indirect ownership intentity higher in a pyramid than the applicant	arest is an entity that has an owners!	nio interast in the applicant e	ntity, Ownership in any
Nema	Businesa Addr	sse/City/State/ZIP	EIN Number
		•	
		,	
			
	CERTIFICATION OF APPLICA	TION	
The undersigned hereby makes application this application, represents and shows that the with the Abortion Clinic statues, IC 16-21-2-2 maintain this clinic in accordance with those	for a license to operate an Aborton (ne owner(s) and operator(s) are of re 1.5 and IC 16-34, and the rules prom rules.	Clinio (Clinio) in the State of i putable and reasonable cha ulgated thare undar, 410 IA	rracter, are able to comply C 26 and will operals and
certify that the operational policias of the c	linic will not provide for discriminat	ion based upon race, color,	craed, or national origin.
I awear end effirm under the penalty of perjur complete and that I will comply with all regula	y that ell statements made in this applicas, laws, and rules governing the	pilestion and any attachment licensing of clinics in Indiene	s thareto are correct end
Signature of the Medical Director:	\rightarrow		
Printeg Mame and Thie:	unatels, Modical Director		
Dela of Signature (mmiddlyyyyJ:	019		
Signature of the Clinic Administrator:		er	
Printed Name end Title:	Weiner, Health Conter Manager		
Date of Signature (mmlddlyyyyJ: 5/15/2	019		
See the following page for		··	

License Fee

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. •	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

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 - (A) A copy (in writing) of the physician's admitting privileges; or

(B) A copy of:

- (1) his/her written agreement with another physician with admitting privileges; and
- (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mail to:

INDIANA STATE DEPARTMENT OF HEALTH CASHIER'S OFFICE P. O. BOX 7236 INDIANAPOLIS, INDIANA 46207-7236



200 South Meridian Street, Sulte 400, Indiampdis 46225
Malling Address P.O. Box 397, Indianapsis 46206-0397
p; 317,637,4343 · f; 317,637,4344
www.ppink.org

Planned Parenthood of Indiana and Kentucky

May 22, 2019

Planned Parenthood of Indiana and Kentucky 964 Mczzanine Dr Lafayette, IN 47905

Re: Backup Agreement for Tippceanoc County

Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency, or other medical need that requires hospitalization.

I have admitting privileges in at at a line and indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate eare should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, Thave provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or eaneel this agreement for any reason.

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November 01, 2017	, , ,	
	And the second s	
RE;		
Dear Sir/Madam:		
Deal ollusidadi.	are committed to the provision of quality care and are	e accre
by	. Our	
are accredited	by the management activities, ongoing professional practice eva	
- Innueral profoncional practice A	SUSTINATION - MAR MODITOF DUF DIRECTIONED IN SIX ELEGS OF 95	3110191
someotopey - nationt care, men	dical/clinical knowledge. Dractice-pased learning and impr	roveme
the amount and communication	ion ckille protessionalism and systems-pased Didulice,	
The shalls prostitioner has mot	t the necessary requirements to maintain clinical privilege ental/Allied Health Staff including professional, moral, ethi	cal and
- memberchip op toe Medicali ie	HidirAffied Fleatiff Staff Hiddening professional, two safe	
nhysical requirements.		
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physical requirements. Facility:		
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physical requirements. Facility: Staff Appointment Date:		
physical requirements. Facility: Staff Appointment Date: Staff Status:		
Physical requirements. Facility: Staff Appointment Date: Staff Status: Department/Section:	ion, please contact me.	
Physical requirements. Facility: Staff Appointment Date: Staff Status: Department/Section:		

June 24, 2019

Randall D Snyder
Division Director, Acute Care
Indiana State Department of Health

RE:

Dear Sir/Madam:

are committed to the provision of quality care and are accredited . Our

are accredited by the engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:

Staff Appointment Date: From:

Staff Status:

Department/Section:

Specialty:

If you need additional information, please contact me.



Eric J. Holcomb

Kristina Box, MD, FACOG State Health Commissioner

June 25, 2019

Facility 011116

LOLITA KINSEY-BROWN
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
200 S. MERIDIAN STREET, SUITE 400
INDIANAPOLIS, IN 46225

Dear LOLITA KINSEY-BROWN:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN

Genrifs Holice Rd

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

317/232-3095

Enclosure (1)



Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Planned Parenthood Of Indiana and Kentucky INC d/b/a
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC
8645 CONNECTICUT ST
MERRILLVILLE, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011116-1 is effective July 1, 2019 and expires June 30, 2020.

STATE OF THE STATE

RANDALL SNYDER PT, MBA DIRECTOR, ACUTE CARE DIVISION

State Form 44840 (R6/5-05)

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

06-JUN-19

RECEIPT NO. 1965425

DIVISION ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

AMOUNT

1,000.00

CASH

CHECKS AND 69340: \$1,000.00

MONEY ORDERS

REFUND

MAIL CLERK Wade, Amber

REMARKS

MERRILLVILLE

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

INDIANA STATE DEPARTMENT OF HEALTH MAIL MONEY RECEIPT

DATE

06-JUN-19

RECEIPT NO.

1965425

DIVISION

ACUTE CARE (AC)

FROM

PLANNED PARENTHOOD

STREET

PO BOX 397

CITY

INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

RECEIVED

JUN -7 2019

Indiana State Department of Health Acute Care Division

AMOUNT

\$

1,000.00

CASH

CHECKS AND

69340:

\$1,000.00

MONEY ORDERS

REFUND

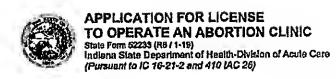
MAIL CLERK Wade, Amber

REMARKS

MERRILLVILLE

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1



		Division	of Acute Care Use Onl	Y	
Deje Received (mm/dd/yyy)	n	Date Appro	ved (mm/dd/yyyy)	Date Reject	ed (mm/dd/yyyy)
Please Type or Print Legibly					
		SECTION	I-TYPE OF APPLICATIO	N	
Application (Check appropri	ate liem.)				
New Facility Renewa	. 🗆	Changa of Ownershi Submit a dated and a	ip (Anticipated date of Salof Ignad copy of the bill of sale, le	Purchaze/Leaso (mr. easo or other docum	niddhyyyy)) ent of trensfer.
		SECTION II -	IDENTIFYING INFORMAT	TON	
A. Abortion Clinic Location			<u></u>		
Name of Abortion Clinio			a.e. a.t. the		
Planned Parenthood o		and Kentucky -	Memiliville		P.O. Box
Streel Address (number and sin					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
8645 Connecticut Stre	et		County		ZIP Code +4
City			Lake		46410
Merrillville Telephone Number Fax Number	nhar		Lako		
(219) (2	(9) -0538	Abortion Clinic e-ma	ill address:_lolita.kinsey-l	orown@ppink.c	org
		Internet Web Addre	ss; www.ppInk.org		
B. Malling Address (if diffe	rent from al	portion clinio location	on)		
Street Address (number and street					P.O. Box
200 S. Meridian Street	Ste. 400				
City			County		ZIP Code +4
Indianapolis			Marion		46225
C. Licensee / Ownership I	iformation				
Licensee: The applicant entity a					
Planned Parenthood o		and Kentucky,	INC		I P.O. Box
Street Address (number and sli					P.O. Box
200 S. Merldian Street	Ste. 400	<u> </u>	State		ZIP Code+4
City			IN		46225
Indianapolls Telephone Number	Fex Num		EIN Number		Fiscal Year End Date (mm/tid)
(317) 637-4343		637-4344	35-0874	276	06/30

D. Services provided u	nder this license:		
Code tiems 1 and 2 as follows:	1. Provided directly by employee	(s). 2. Provided by a contract service, 3. Both 1 and 2.	
1. Ancillary Services:	· · · · · · · · · · · · · · · · · · ·	rdificate Number 1500360690 Pharmacy Other (List):	Radiology Counseling
2. Abortion Services:		Surgical Only Both Drug Ind	
For Item 3. indicate the total n	nmpet at marroluis teutnoless bu	or connuctors asserted or the stant - or consession	
		2 Licensed Practical Nurses: 0	Licensed Social Workers: 0
Other (List title and nur	nber, do not use acronyms):		
E. Number of Proces	lure Rooms Utilizing:		•
	Minimal Sedation 2	Moderate Sedation	9
F. Type of Entity:			
F. Type of Entity: For Profit		Non-Profit	Government
For Profit		Non-Froiit Church Rolated	Government ☐ State
			☐ State
For Profit		☐ Church Rolated ☐ Individuel ☐ Partnership	State County City
For Profit Individuel Partnership	ny	☐ Church Rolated ☐ Individual ☐ Partnership ☑ Corporation	State County City City/County
For Profit Individual Partnarship Corporation Limited Liability Compa	ny	Church Rolated Individual Partnership Corporation Umited Hability Company	☐ State ☐ County ☐ City ☐ City/County ☐ Hospitel District
For Profit Individual Partnership Corporation Limited Liability Compa	ny	☐ Church Rolated ☐ Individual ☐ Partnership ☑ Corporation	State County City City/County Hospital District
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For Profit Individual Partnarship Corporation Limited Liability Compa	ny	Church Rolated Individual Partnership Corporation Umited Hability Company	State County City City/County Hospital District
For Profit Individual Partnarship Corporation Limited Liability Compa	ny	Church Rolated Individual Partnership Corporation Umited Hability Company	State County City City/County Hospital District

G. Officers if the business entity is inc. Position	Name	Address/City/State/ZIP
President / Chalrperson / CEO	Donna Кел	200 S Meridian St. Ste. 400 Indianapolis, IN 46223
Vice-President / Vice-Chairperson / COO	Kristen Roby Dimlow	200 S Meridian St. Ste. 490 Indianapolis, IN 4522
Treasurer / CFO	Terri Pickens Manweil	200 S Meridian St. Ste. 400 Indianapolis, IN 4622
Secretary	Tuan Ngo	200 S Meridian St. Ste. 400 Indianapolis, IN 4622
 Ownership and/or Change in Ownershi let namee and addresses of individuals or on the applicant antity, indirect ownership into antity higher in a pyramid than the applicant 	nganizations having direct or indirect of	ownership or controlling interest of five percent (5%) p interest in the epplicant entity. Ownership in any additional sheet if necessary.)
antity nigher in a pyramic inan ina applicant Name	Business Addres	s/City/State/ZIP EIN Numbar
<u></u>		
	,	
. Decleratione:		
Hes any opplicant, or an owner or efficiete of and safety concerns? YES NO		Inic that was closed as a direct result of patient heat
Has any principal or clinic staff member been		
administrative or legal action? ☐ YES	₹ NO	rated by the applicant that closed as a result of
For any YES responses: attach copies of adm		spection reports, violations and remediation contracts
Plan and and an att to a state of the state	GERTIFICATION OF APPLICAT	
thia application, represents end shows that t with tha Abortion Cilnic atatuee, IC 16-21-2-; meintain this clinic in eccordance with those	he owner(e) and operator(a) are of rep 2.5 and IC 18-34, and the rules promul rules.	linic (Clinic) in the State of Indiana, and in support of xuteble end resecnable character, ere ebte to compl igated there under, 410 IAC 26 and will operate end
		based upon race, color, creed, or national origin.
-	ry that all statements made in this epp	plication and any attachments thereto ere correct an
Signeture of the Medical Diractor:	_	
Printed Name and Tille:	Deb Nucatola, Medical Director	,
Date of Signature (mm/dd/yyyy):	6/21/19	
Signature of the Clinto Administrator:	of the Kinsey Bro	There are a second and a second are a second
Printed Name and Title:	Lolita Kinsey-Brown, Area Sen	
Date of Signeture (mm/dd/yyyy):	6/20/19	
See the following page for		licensure fees and submissio

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

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410 IAC 15-5-3

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(B) A copy of:

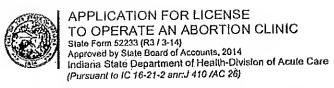
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INDIANA STATE DEPARTMENT OF HEALTH ATTENTION: CASHIER'S OFFICE, 2-C 2 NORTH MERIDIAN STREET INDIANAPOLIS, INDIANA 46204



		Division of Ac	cute Care Use Only		
Date Received (m	middlyyyy)	Date Approved (m	mlddlyyyy),	Dale Rejected (mmlddlyy)	/у),
Please T""e orPri	nt Legib/v.				, <u>, , , , , , , , , , , , , , , , , , </u>
			PE OF APPLICATION		
Application (Chec	h=	Observe of Ownership / Anli	cipated date of Sale/Purc by of the bill of sale, lease	hase/Lease (mmlddlyyyy)) or other document of transfer.	
	<u> </u>	SECTION II - IDEN	TIFYING INFORMATIO	N	
A. Abortion Glinic	Location				
Name of Abortion Cli	nto	y – Memivile			
Ştreel Address (num 8645 Connecticut Stree	bar and street) l			P.O. E	Box
City Merriville			County Lake	ZIP Co 46410	ode +4
Telephone Number	Fax Number				•
(317)872-3115	(317)872-3118	At-day Office a mail add	ress: Lolita.kinsey-brown	a)ooink.oru.	
		Internet Web Address;	www.ppink.org		
	NE distance A frame of	l bortion clinic location)			
Street Address (numb	er and street)	DOTAGIT CHING IOGUNOTY		P.O. E	Зох
200 South Meridian,	Suita 400		0	ZIP C	ode +4
City			County		000 14
Indianapolis Marion			46225		
C. Licensee/Owne Licensee: The applica	rship Information ant entity as registere	d with the secretary of state			
Planned Parenthood of Street Address (number	er and street)	y, INC		P.O. E	Зох
200 South Meridian S City Indianapolis	Street, Sulte 400		Slate	ZIP C	ode+4
meranakana			Indiana	46225	
Telephone Number	Fax Nun (317) 63		N.Mumber 35-0874276	Fiscal Year B	End Date (mmldd)

D. Services provided under this license:		
Code items 1 and 2 as fullows. 1. Provided directly by employs	vets). 2. Provided by a contract service, 3. Both 1 and 2	
Service strains a many in the factories.		•
1. Ancillary Services: 1 Laboratory: CLIA C	Certificate Number 1500360690	Radiology Counseling
1 Family Plenning	Pharmacy Other (List):	
	Other (List):	• • • • • • • • • • • • • • • • • • •
For item 3, indicate the total number of individuals (employees)	dus contractors) working in this clinic. This includes ho	wly, part-time, and full-time persons
3. Staffing: Physicians: Registered Nurses		
Licensed Social Workers:	Other (List title and number): _^	DRN & HALLING AMERICAN STREETS CHARLESTERS
E. Number of Procedure Rooms Utilizing:		
Local anatgesia/anesthetic 2	Moderate/Conscious Sedation	
Local analgesia/anesthetic 2 F. Type of Entity:		
Local analysis/alestiletic	Moderate/Conscious Sedation	Government
F. Type of Entity:		Government State
F. Type of Entity:	Non-Profit	Government State County
F. Type of Entity: For Profit Individual	Non-Profit Church Related	Government State County City
F. Type of Entity: For Profit Individual Partnership	Non-Profit Church Related Individuel Partnership Corporation	Government State County City City/County
F. Type of Entity: For Profit Individual Partnership Corporation	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company	Non-Profit Church Related Individuel Partnership Corporation	Government State County City City/County
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District
F. Type of Entity: For Profit Individual Partnership Corporation Limited Liability Company Sole Proprietorship	Non-Profit Church Related Individual Pártnership Corporation Limited Liability Company	Government State County City City/County Hospital District

Position		Nama		85/Cily/State/ZIP
Presidont/Chakperson/CEO	Donna	Kerr	200 South Merkilan. Indianapolis, IN 4622	25
Vice-PresidenWice-Chairperson/COO	Kristen	Roby Dimlow	200 South Merkilon. Indianapolis, 1N 4623	
Treasurer/CFO	Terri Pi	ickens Manwell	200 South Meridian, Indianapolis, IN 4622	Suite 40h 15
Secretary	Tuan Ngo		200 South Merklium. Indianapolis, 114 462	
d. Ownership and/or Change in Owners	hip:		·	
List names and addresses of individuals or n the applicant entity, Indire of ownership in milly higher in a pyramid than the applicant	organizatio	s indirect ownership. (Use at	iditional shoot if nacosso,y	, , , , , , , , , , , , , , , , , , , ,
Name		Business Addres	s/City/State/ZIP	EIN Number
	"			
				
	CER'	TIFICATION OF APPLICAT	non	
The undersigns of hereby makes application its opplication, represents and shows that with the Abortion Clinic statues, IC 16-21-2-naintain this clinio in accordance with those cartify that the operational policies of the	i for a licen the owner(2.5 and IC e rules, olinic will i	se to opsrate an Abortion C s) and operator(s) ere of rep 16-34, and the rules promu- not provide for discrimination	linio (Cilnic) in the State of utside and reasonable chi igated there under, 410 fA in based upon race, color	C 26 and will operate an
swear and affirm under the penalty of penu complete and that I will comply with all regul	ny ihal eli s ations, law	statements made in this applies, and rules governing the lice	ication and any allechment tensing of clinics in Indiana	r Retaile ete coltect eu
Signature of the Madical Director:	1)		
rinled Name and Title:	Deb Neestoff, Medical Director			
S/15/	2019 .//.			
ignsture of the Clinic Administrator:	Phta Kinsey-Bro	Kinsu-Bro	wn	
rinted Name and Title:	1 Kinsey-un 2019	SKIL /HED SCI STOP DIRECTOR		1
NOTE A				

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fae
Offe	Zero to 799	\$500.00
X	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

Enclose the following:

- 1. A completed Application for Licanse to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's edmitting privileges; or (BJ A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges.
- 4. Payment made payable to "Indiana State Department of Health."

Mall to:

INDIANA STATE DEPARTMENT OF HEALTH
CASHIER'S OFFICE
P. 0. BOX 7236
INDIANAPOLIS, INDIANA 46207-7236



Planned Parenthood of Indiana and Kentucky

May 22, 2019

Planned Parenthood of Indiana and Kentucky 8645 Connecticut St Merrillville, IN 46410

Re: Backup Agreement for Lake County

Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have admitting privileges in at in Indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

l agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely,	
Electronic signature for	

April 27, 2018

Dear

On behalf of the Board of Trustees, it is my pleasure to Inform you that your reappointment to the Medical Staff has been approved. You have been granted membership on the Active staff with clinical privileges in beginning through

Clinical privileges have been granted as specified on the enclosed Privileges form. Please review these carefully, as you have only been granted privileges to perform those procedures outlined on your Delineation of Privileges form.

As a member of the Medical Staff, you are required to abide by all hospital policies and the Code of Ethical Conduct. Your reappointment is subject to the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and all other Medical Staff Policies and Procedures that are in force during the term of your appointment.

Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office for assistance at

We appreciate your continued support and value your contribution as a member of the Medical Staff.

Sincerely,

Enclosure: Clinical Privileges



Eric J. Holcomb Governor

Kristina Box, MD, FACOG State Health Commissioner

Abortion Clinic Licensure Physician Admitting Privileges Verification Report

Date: 06/24/2019

Clinic: Planned Parenthood Of Indiana And Kentucky Inc

8645 Connecticut St

Merriliville, IN 46410-6222

Reason for Verification:xLicensureStatus Change	
IC 16-34-2-4.5(a)(1) Admitting Privileges (without a written agreement with another physician)	
Clinic Physician's Name:	
Hospital:	ĺ
Confirmed by:	
(Name and Title of Hospital Representative)	
Date Verified:	
Verified by:	
	الماملىدى ومريد
IC 16-34-2-4.5(a)(2) Admitting privileges under a written agreement with another physician	CALANIA PROPERTY
Name of Clinic Physician covered by the agreement:	,
·	
Admitting Physician	}
Hospital:	
Confirmed by: (Name and Title of Hospital Representative)	
Date Verified: June 24, 2019	
Verified by: R. Snyder, Division Director Acute Care	



Eric J. Holcomb Governer

Kristina Box, MD, FACOG Stato Health Commissioner



June 7, 2019

Facility 011128

W. MARTIN HASKELL, M.D. WOMEN'S MED GROUP PROFESSIONAL CORPORATION PO BOX 43100 CINCINNATI, OH 45243

Dear W. MARTIN HASKELL, M.D.:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2019 through June 30, 2020.

Sincerely,

JENNIFER HEMBREE RN

Gennifs Hedre RN

Nurse Surveyor Supervisor

Program Director Hospitals/ASCs

317/232-3095

Englosure (1)



Indiana State Department of Health

Abortion Clinic License

This is to certify that:

Women's Med Group Professional Corporation d/b/a

WOMEN'S MED GROUP PROFESSIONAL CORPORATION 1201 N ARLINGTON AVE INDIANAPOLIS, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 19-011128-1 is effective July 1, 2019 and expires June 30, 2020.

Rampall Smyden

RANDALL SNYDER PT, MBA DIRECTOR, ACUTE CARE DIVISION

State Form 44840, (R655-05)

INDIANA STATE DEPARTMENT OF HEALTH

MAIL MONEY RECEIPT

用部 #7 25 -

Indiana State Department of Frentil.

Acute Care Division

DATE

31-MAY-19

RECEIPT NO. 1964699

DIVISION

ACUTE CARE (AC)

FROM

THE NOMEN'S MED & CENTER

STREET

PO BOX 43100

CITY

CINCINNATI

STATE Oil

- 45243

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 185129)

1,000,00

AMOUNT

\$

1,000.00

Cash

CHECKS AND MONEY ORDERS 61092:

\$1,000.00

REFUND

MAIL CLERK Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MATE REFEIR I

SBR 10-0008 "APPROVED BY STATE BOARD OF ACCOUNTS, 2004"

INDIANA STATE DEPARTMENT OF HEALTH

. " 117 21

MAIL MONEY RECEIPT

Indiana State Department of Health Acute Care Division

DATE

RECEIPT NO.

31-MAY-19

DIVISION ACUTE CARE (AC)

1964699

PROM

THE WOMEN'S MED & CENTER

STREET

PO BOX 43100

CITY

CIRCINNATI

STATE OH

45243

LICENSE TO OPERATE ABORTION CLINIC (Fund: 17610, Program: 30000,

1,000.00

Account: 423010, Department: 195129)

THUOMA

1,000.00

CASH

CHECKS AND MONEY ORDERS 61092;

\$1,000.00

REFUND

MAIL CLERK Wade, Amber

REMARKS

State FORM 1086 (R7/12-04)

MAIL MR/FIN 1

APPLICATION FOR LICENSE TO OPERATE AN ABORTION CLINIC State Form 52233 (Re / 1-19) Indiana State Department of Heelth-Division of Acute Cere (Pursuant to IC 16-21-2 and 410 IAC 28)

RECEIVED

JUN 07 2019

Indiana State Department of Health Acute Care Division

lease Type or Print Le		Date Approved	(mm/dd/yyyy)	Date Rejected	i (mm/dd/yyyy)
	e <i>gibly</i> .				
		·			
		SECTION I - 1	TYPE OF APPLICATI	ON	
Application (Check et	• •	Change of Ownership (/ Submil a deled end signe	Anticipated date of Sale d copy of the bill of sale,	e/Purchase/Lease (mm/d lease or other dooumen	id/yyyy)) t of transfer.
,		SECTION II - IDI	ENTIFYING INFORMA	ATION	
A. Abortion Clinic Lo Name of Abortion Clinio Women's Med Gr Street Address (number of	roup Profession	onal Corporation di	oa Women's Med	indianapolis	P.O. Box
1201 N Arlington					
City	7/0		County		ZIP Code +4
indianapolis			Marion		46219
Telephone Number F (317) 353 9371	(317) 322 3358		ddress: martyh@fo		
D. M. Hink Address	lif different from :	abortion clinic location)			
Street Address (number	end street)	and the control of th			P.O. Box 43100
City			County		ZIP Code +4
Cincinnati, OH			Hamilton		45243-0100
C. Licensee / Owner Licensee: The applicant	t entity as registere	d with the secretary of siz	te·		
Women's Med Gi	rend street)	oliai Corboration			P.O. Box 43100
City	·		State OH		ZIP Code+4 .45243-0100
Cincinnati Telephone Number (513) 272 0002	Fax Nu	mber) 272 0052	EIN Number 31-114		Fiscal Year End Date (mm/dd) 12/31

D. Servicee provided t	under this license:	
i	: 1. Provided directly by employee(s), 2. Provided by a contract service, 3.	. Both 1 and 2,
1. Ancillary Services:	3 Laboratory: CLIA Certificate Number 15D353797	1 Radlology 1 Counseling
	1 Family Planning 1 Pharmacy Other (L.	ist):
2. Abortion Services:	Drug Induced Only Surgical Only Bot	
For item 3, Indicate the lotal n	number of individuals (employees plus contractors) working in this clinic. This	s includes hourly, part-time, and full-time persons,
3, Staffing; Physicians	Registered Nurses: 0 Licensed Practical Nurse	Licensed Social Workers: 0
Other (List title and nur	nber, do not use acronyms): Advanca Practice Nurses	3, Medical Assistants 5
E. Number of Proced	lure Rooms Utilizing:	
	Minimal Sedation 2 Moderate Se	edation 0
F. Type of Entity:		
For Profit	Non-Profit	Government
☐ Individual	Church Related	☐ State
Partnership	☐ Individual	County
☑ Corporation	Parlnership	City
Limited Liability Compa	ny Gorporation	City/County
Sola Proprietorship	Limited Liability Company	Hospital District
Other (specify)	Olhar (specify)	Federal
		Other (specify)
]		

G. Officers of the business entity is incorposition	Name	Address/City/State/ZIP	
President / Chairperson / CEO	Martin Haskell, MD	PO Box 43100, Cincinnati OH 45243	
Vice-President / Vice-Chairperson / COO	Valerie Haskell	PO Box 43100, Cincinnati Oi- 45243	
Treasurer / CFO	Martin Haskell, MD	PO Box 43100, Cincinnati OH 45243	
Sacretary	Valerie Haskell	PO Box 43100, Cincinnati OH 45243	
H. Ownership and/or Change in Ownershi List names and eddresses of Individuals or o in the applicant entity, Indirect ownership into entity higher in a pyramid than the epplicant	rganizations having direct or indirect	ownership or controlling interest of five percent (5%) Ip interest in the epplicent entity. Ownership in any additional sheet if necessary.)	
Name	Business Addre	ess/Clty/Stete/ZtP EIN Number	
Martin Haşkeli, MD	PO Box 43100, Cinc	PO Box 43100, Cincinnati, OH 45243	
]. Declarations:	the applicant operated an abortion	clinio that was closed as a direct result of patient health	
end safety concerns?	the opposing operator of the		
Has any principal or clinic eteff member bee			
edministrative or legel ection?	MIMO	ereted by the epplicant that closed es e result of	
For any YES responses: attach copies of edu	ninistrative and legal documentation, a CERTIFICATION OF APPLICA	inspection reports, violetions and ramadiation contracts.	
this application, rapresents and shows that i with the Abortion Clinic statues, IC 16-21-2- maintain this clinic in eccordance with those	for e license to operate en Abortion (he owner(s) and operator(s) are of re 2.5 end tO 16-34, and the rules prom rules.	Clinio (Clinic) in the State of Indiena, and in support of eputebla and reasonable charecter, are abla to comply julgated there under, 410 IAC 28 end will operate and	
I certify that the operational policies of the c	linlo will not provide for discrimination	based upon race, color, creed, or national origin.	
I swaar and affirm under the penalty of perjudicemplete and that I will comply with all regul	ry that all stataments made in this a lations, lawe, end rules governing the	oplication and any atlachments thereto are correct and allowing of cilnics in Indiane.	
Signature of the Medicel Director:	Month	9'	
Printad Name and Titta:	Martin Haskell		
Dete of Signature (mm/dd/yyyy):	June 19, 2019		
Stgnature of the Ctinic Administrator:	1 Afath		
Printed Neme and Title:	Valerie Haskell, Vice-Preside	nt i	
Dete of Signeture (min/dd/yyyy):	June 10, 2019		
See the following page for	<u>'instructions regardin</u>	g licensure fees and submission	
of this application.			

License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

410 IAC 15-5-3

Enclose the following:

- 1. A completed Application for License to Operate an Abortion Clinic (this form).
- 2. Any supporting attachments.
- 3. For each physician performing procedures, either:
 - (A) A copy (in writing) of the physician's admitting privileges; or
 - (B) A copy of:
 - (1) his/her written agreement with another physician with admitting privileges; and
 - (2) a copy (in writing) of that physician's admitting privileges,
- 4. Payment made payable to "Indiana State Department of Health."

Mall to:

INDIANA STATE DEPARTMENT OF HEALTH ATTENTION: CASHIER'S OFFICE, 2-C 2 NORTH MERIDIAN STREET INDIANAPOLIS, INDIANA 46204

10:472

Indiana State Department of Health Acute Care Division

May 22, 2019

RE: Backup Agreement in Marion County, Indiana

Dear Dra.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have privileges in at in Indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per medical standard of care, any patient needing immediate care should be evaluated at the nearest emergency care contor.

In the event my services are needed under this agreement, centact me by calling the shared phone numbers. I have provided you with my office and cell phone numbers. Please provide the patient's name, reason for referral, current medical condition, and means of transport. A copy of all available patient records should be sent with the patient if possible.

Attached is current proof of hespital privileges. I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincercly.

11 117

Indiana State Department of Health.
Acute Care Division

January 15, 2019

Dear

It is my pleasure to inform you that the has approved your reappointment at

In the

1. You have been reappointed to the Active category.

Your approved clinical privileges are effective:

Your reappointment date is

Please log on to ____ carefully review your approved privileges for any modifications to the original submission. The ____ instructions are attached. If you need a copy of your clinical privileges, please contact ____ or ____

Medical Staff members (physicians and dentists) in the Active entegory: if you are not currently hoard certified, please review.

Sincerely,

Attachment

**:

June 24, 2019

To Whom It May Concern:

This letter is to verify that was granted temporary privileges on '. He was appointed to the Medical Staff of '. on '.

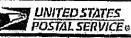
is an Active member of our department and has admitting privileges. He meets the necessary requirements to maintain membership and/or clinical privileges on the Medical Staff.

If you have any further questions, please contact me at

Sincerely,

JUN 07 2019

Indiana Slate Department of Health Acute Care Division



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Malléd Irom 45243

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PRIORITY MAIL 2-DAY™

MARTIN HASKELL FORTE MANAGEMENT CORP PO BOX 43100 CÍNGINNATI ÓH 45243-0100

Expected Delivery Date: 05/09/10

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Carrier -- Leave if No Response

B053

INDI236 46207-RES-1818 *94 05/28/19 NOTIFY SENDER OF NEW ADDRESS :INDIANA STATE DEPT OF HEALTH 2 N MERIDIAN ST INDIANAPOLIS IN 46204-3006

RF

USPS TRACKING#



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